

		FOR OHF USE					

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0036897</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																									
Facility Name: <u>Convalescent Care Ctr-Mattoon</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2002</u> to <u>10/31/2002</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.																									
Address: <u>1000 PALM STREET</u> <u>MATTOON</u> <u>61938</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																									
County: <u>COLES</u>		Officer or Administrator of Provider (Signed) _____ (Date) _____ (Type or Print Name) <u>Junior Foster, THSCLLC, Mgt. Co. for</u> (Title) <u>Convalescent Care Center of Mattoon</u>																									
Telephone Number: <u>(217) 234-7403</u> Fax # <u>(217) 258-6642</u>		Paid Preparer (Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>()</u> Fax # <u>()</u>																									
IDPA ID Number: <u>43-157001</u>		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630																									
Date of Initial License for Current Owners: <u>01/00/00</u>																											
Type of Ownership: <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table>		<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input checked="" type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____			
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																									
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	<input type="checkbox"/> Limited Liability Co.																										
	<input type="checkbox"/> Trust																										
	<input type="checkbox"/> Other _____																										
In the event there are further questions about this report, please contact: Name: <u>Karl Baker, BKD, LLP</u> Telephone Number: <u>314-231-5544</u>																											

STATE OF ILLINOIS

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Facility Name & ID Number Convalescent Care Center of Mattoon# 0036897 Report Period Beginning: 1/1/2002 Ending: 10/31/2002

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>134</u>	Skilled (SNF)	<u>134</u>	<u>40,736</u>	1
2	<u>0</u>	Skilled Pediatric (SNF/PED)	<u>0</u>	<u>0</u>	2
3	<u>0</u>	Intermediate (ICF)	<u>0</u>	<u>0</u>	3
4	<u>0</u>	Intermediate/DD	<u>0</u>	<u>0</u>	4
5	<u>0</u>	Sheltered Care (SC)	<u>0</u>	<u>0</u>	5
6	<u>0</u>	ICF/DD 16 or Less	<u>0</u>	<u>0</u>	6
7	<u>134</u>	TOTALS	<u>134</u>	<u>40,736</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>1,256</u>	<u>0</u>	<u>1,091</u>	<u>2,347</u>	8
9	SNF/PED	<u>0</u>	<u>0</u>	<u>0</u>		9
10	ICF	<u>17,774</u>	<u>2,311</u>	<u>0</u>	<u>20,085</u>	10
11	ICF/DD	<u>0</u>	<u>0</u>	<u>0</u>		11
12	SC	<u>0</u>	<u>0</u>	<u>0</u>		12
13	DD 16 OR LESS	<u>0</u>	<u>0</u>	<u>0</u>		13
14	TOTALS	<u>19,030</u>	<u>2,311</u>	<u>1,091</u>	<u>22,432</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 55.07%

D. How many bed-hold days during this year were paid by Public Aid?

0 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)N/A - None

F. Does the facility maintain a daily midnight census?

YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started NOT AVAILABLE

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date not available NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter number of beds certified 14 and days of care provided 1,091Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCURAL ☒ MODIFIED CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/2002 Fiscal Year: 12/31/2002

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

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Facility Name & ID Number

Convalescent Care Ctr-Mattoon

0036897

Report Period Beginning:

1/1/2002

Ending:

10/31/2002

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	134,785	11,074	4,234	150,093		150,093	(1,206)	148,887		1
2	Food Purchase		116,780		116,780		116,780		116,780		2
3	Housekeeping	87,133	11,256		98,389		98,389		98,389		3
4	Laundry	41,037	14,620		55,657		55,657		55,657		4
5	Heat and Other Utilities			118,657	118,657		118,657		118,657		5
6	Maintenance	32,065	11,612	36,547	80,224		80,224		80,224		6
7	Other (specify):*			5,785	5,785		5,785		5,785		7
8	TOTAL General Services	295,020	165,342	165,223	625,585		625,585	(1,206)	624,379		8
	B. Health Care and Programs										
9	Medical Director			8,912	8,912		8,912		8,912		9
10	Nursing and Medical Records	938,139	63,609	70,245	1,071,993		1,071,993		1,071,993		10
10a	Therapy		129	64,894	65,023		65,023		65,023		10a
11	Activities	27,474	1,268	2,546	31,288		31,288		31,288		11
12	Social Services	71,771	6	2,246	74,023		74,023		74,023		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,037,384	65,012	148,843	1,251,239		1,251,239		1,251,239		16
	C. General Administration										
17	Administrative	47,913			47,913		47,913		47,913		17
18	Directors Fees										18
19	Professional Services			178,018	178,018		178,018		178,018		19
20	Dues, Fees, Subscriptions & Promotions			26,075	26,075		26,075		26,075		20
21	Clerical & General Office Expenses	55,428	18,534	36,621	110,583		110,583	(174)	110,409		21
22	Employee Benefits & Payroll Taxes			187,844	187,844		187,844		187,844		22
23	Inservice Training & Education			231	231		231		231		23
24	Travel and Seminar			11,577	11,577		11,577		11,577		24
25	Other Admin. Staff Transportation			6,142	6,142		6,142		6,142		25
26	Insurance-Prop.Liab.Malpractice			149,365	149,365		149,365		149,365		26
27	Other (specify):*										27
28	TOTAL General Administration	103,341	18,534	595,873	717,748		717,748	(174)	717,574		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,435,745	248,888	909,939	2,594,572		2,594,572	(1,380)	2,593,192		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

STATE OF ILLINOIS

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Facility Name & ID Number

Convalescent Care Ctr-Mattoon

#0036897

Report Period Beginning:

1/1/2002

Ending:

10/31/2002

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			58,822	58,822		58,822	38,416	97,238			30
31	Amortization of Pre-Op. & Org.			667	667		667	(667)				31
32	Interest			47,598	47,598		47,598		47,598			32
33	Real Estate Taxes			14,500	14,500		14,500		14,500			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			2,656	2,656		2,656		2,656			35
36	Other (specify):*			(174)	(174)		(174)		(174)			36
37	TOTAL Ownership			124,069	124,069		124,069	37,749	161,818			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		69,094	44,398	113,492		113,492		113,492			39
40	Barber and Beauty Shops							(89)	(89)			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			81,168	81,168		81,168		81,168			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		69,094	125,566	194,660		194,660	(89)	194,571			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,435,745	317,982	1,159,574	2,913,301		2,913,301	36,280	2,949,581			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

STATE OF ILLINOIS

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Facility Name & ID Number Convalescent Care Ctr-Mattoon

0036897

Report Period Beginning: 1/1/2002

Ending: 10/31/2002

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(3,921)	1		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(16,017)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(12,757)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule (See page 5a)	36,947			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 4,252		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense	(667)	31	33
	Adjustments for Related Organization			
34	Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (667)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 3,585		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	\$		38
39			X			39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Convalescent Care Ctr-Mattoon

ID# 0036897

Report Period Beginning: 1/1/2002

Ending: 10/31/2002

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Vendor Income	\$ (1,206)	1	1
2	Barber and Beauty Revenue	(89)	40	2
3	Extraordinary Income/(Expense)		21	3
4	(Gain)/Loss on Sale of Assets		30	4
5	Miscellaneous (Income)/Expense	(174)	21	5
6	Adjust Depreciation Expense to Schedule XI	38,416	30	6
7	Raw foods rebate		2	7
8	Adjust R/E taxes to actual		33	8
9	Miscellaneous Expense		21	9
10	Home Office Allocation		21	10
11	Lobbying portion of IHCA dues		21	11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	36,947		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Convalescent Care Ctr-Mattoon

0036897

Report Period Beginning:

1/1/2002

Ending:

10/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	(1,206)	0	0	0	0	0	0	0	0	0	0	(1,206)	1
2	Food Purchase	(32,695)	0	0	0	0	0	0	0	0	0	0	(32,695)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	(32,695)	0	0	0	0	0	0	0	0	0	0	(32,695)	7
8	TOTAL General Services	(66,596)	0	0	0	0	0	0	0	0	0	0	(66,596)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(174)	0	0	0	0	0	0	0	0	0	0	(174)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(174)	0	0	0	0	0	0	0	0	0	0	(174)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(66,770)	0	0	0	0	0	0	0	0	0	0	(66,770)	29

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
N/A						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger	4 Amount	5 Cost to Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
			Item		Name of Related Organization				
1	V	0	0	\$	0	0.00%	\$ 0	\$	1
2	V	0	0		0	0.00%	0		2
3	V	0	0		0	0.00%	0		3
4	V	0	0		0	0.00%	0		4
5	V	0	0		0	0.00%	0		5
6	V	0	0		0	0.00%	0		6
7	V	0	0		0	0.00%	0		7
8	V	0	0		0	0.00%	0		8
9	V	0	0		0	0.00%	0		9
10	V	0	0		0	0.00%	0		10
11	V	0	0		0	0.00%	0		11
12	V	0	0		0	0.00%	0		12
13	V	0	0		0	0.00%	0		13
14	Total			\$			\$	\$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Convalescent Care Ctr-Mattoon# 0036897Report Period Beginning: 1/1/2002Ending: 10/31/2002

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V	0	\$	0	0.00%	\$ 0	\$	15
16	V	0		0	0.00%	0		16
17	V	0		0	0.00%	0		17
18	V	0		0	0.00%	0		18
19	V	0		0	0.00%	0		19
20	V	0		0	0.00%	0		20
21	V	0		0	0.00%	0		21
22	V	0		0	0.00%	0		22
23	V	0		0	0.00%	0		23
24	V	0				0		24
25	V	0				0		25
26	V	0				0		26
27	V	0				0		27
28	V	0				0		28
29	V	0				0		29
30	V	0				0		30
31	V	0				0		31
32	V	0				0		32
33	V	0				0		33
34	V	0				0		34
35	V	0				0		35
36	V	0				0		36
37	V	0				0		37
38	V	0				0		38
39	Total		\$			\$ 0	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Convalescent Care Ctr-Mattoon# 0036897Report Period Beginning: 1/1/2002Ending: 10/31/2002

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	0	\$ *

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Convalescent Care Ctr-Mattoon# 0036897Report Period Beginning: 1/1/2002Ending: 10/31/2002

VII. RELATED PARTIES (continued)

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15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 0	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Convalescent Care Ctr-Mattoon# 0036897Report Period Beginning: 1/1/2002Ending: 10/31/2002

VII. RELATED PARTIES (continued)

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15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 0	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Convalescent Care Ctr-Mattoon# 0036897Report Period Beginning: 1/1/2002Ending: 10/31/2002

VII. RELATED PARTIES (continued)

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		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 0	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Convalescent Care Ctr-Mattoon# 0036897Report Period Beginning: 1/1/2002Ending: 10/31/2002

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

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		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 0	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Convalescent Care Ctr-Mattoon# 0036897Report Period Beginning: 1/1/2002Ending: 10/31/2002

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

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		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 0	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Convalescent Care Ctr-Mattoon# 0036897Report Period Beginning: 1/1/2002Ending: 10/31/2002

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

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		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 0	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Convalescent Care Ctr-Mattoon# 0036897Report Period Beginning: 1/1/2002Ending: 10/31/2002

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

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		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 0	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

STATE OF ILLINOIS

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Facility Name & ID Number Convalescent Care Ctr-Mattoon # 0036897 Report Period Beginning: 1/1/2002 Ending: 10/31/2002

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Convalescent Care Ctr-Mattoon # 0036897 Report Period Beginning: 1/1/2002 Ending: 0/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization 0
 Street Address 0
 City / State / Zip Code 0
 Phone Number (0
 Fax Number (0

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	0	0	0	0	\$ 0	\$ 0	0	0	1
2	0	0	0	0	0	0	0	0	2
3	0	0	0	0	0	0	0	0	3
4	0	0	0	0	0	0	0	0	4
5	0	0	0	0	0	0	0	0	5
6	0	0	0	0	0	0	0	0	6
7	0	0	0	0	0	0	0	0	7
8	0	0	0	0	0	0	0	0	8
9	0	0	0	0	0	0	0	0	9
10	0	0	0	0	0	0	0	0	10
11	0	0	0	0	0	0	0	0	11
12	0	0	0	0	0	0	0	0	12
13	0	0	0	0	0	0	0	0	13
14	0	0	0	0	0	0	0	0	14
15	0	0	0	0	0	0	0	0	15
16	0	0	0	0	0	0	0	0	16
17	0	0	0	0	0	0	0	0	17
18	0	0	0	0	0	0	0	0	18
19	0	0	0	0	0	0	0	0	19
20	0	0	0	0	0	0	0	0	20
21	0	0	0	0	0	0	0	0	21
22	0	0	0	0	0	0	0	0	22
23	0	0			0				23
24	0	0			0				24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number Convalescent Care Ctr-Mattoon # 0036897 Report Period Beginning: 1/1/2002 Ending: 0/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

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Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
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1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number Convalescent Care Ctr-Mattoon # 0036897 Report Period Beginning: 1/1/2002 Ending: 0/31/2002

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1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number Convalescent Care Ctr-Mattoon # 0036897 Report Period Beginning: 1/1/2002 Ending: 0/31/2002

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1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number Convalescent Care Ctr-Mattoon # 0036897 Report Period Beginning: 1/1/2002 Ending: 0/31/2002

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1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number Convalescent Care Ctr-Mattoon # 0036897 Report Period Beginning: 1/1/2002 Ending: 0/31/2002

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1					\$	\$		\$	1
2									2
3									3
4									4
5									5
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7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

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1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number Convalescent Care Ctr-Mattoon # 0036897 Report Period Beginning: 1/1/2002 Ending: 0/31/2002

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1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number Convalescent Care Ctr-Mattoon # 0036897 Report Period Beginning: 1/1/2002 Ending: 0/31/2002

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1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number Convalescent Care Ctr-Mattoon # 0036897 Report Period Beginning: 1/1/2002 Ending: 0/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Payable to Mattoon Loan		X		Varies	Varies	\$ 350,000	\$ 160,000		0.1100	\$ 17,402	1	
2	Due to Mattoon, Inc.		X		Varies		10,000	9,973				2	
3	THCM, LP				Varies	7/1/01		295,595			26,263	3	
4	South Side Loan		X				25,000	151,000				4	
5												5	
	Working Capital												
6	Interest Income		X									6	
7	H/O Interest Income											7	
8	Line of Credit			Building Project				154,138			3,933	8	
9	TOTAL Facility Related						\$ 385,000	\$ 770,706			\$ 47,598	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 385,000	\$ 770,706			\$ 47,598	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

Facility Name & ID Number **Convalescent Care Ctr-Mattoon**# **0036897** Report Period Beginning: **1/1/2002** Ending: **10/31/2002****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2001 report.		\$ 20,752	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$ 20,752	2
3. Under or (over) accrual (line 2 minus line 1).		\$	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 14,500	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ 14,500	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	1997 39,942	8	
	1998 42,488	9	
	1999 40,467	10	
	2000 41,675	11	
	2001 20,752	12	
		FOR OHF USE ONLY	
		13 FROM R. E. TAX STATEMENT FOR 2001 \$	13
		14 PLUS APPEAL COST FROM LINE 5 \$	14
		15 LESS REFUND FROM LINE 6 \$	15
		16 AMOUNT TO USE FOR RATE CALCULATION \$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Convalescent Care Ctr-Mattoon COUNTY COLES

FACILITY IDPH LICENSE NUMBER 0036897

CONTACT PERSON REGARDING THIS REPORT Karl Baker, BKD, LLP

TELEPHONE 314-231-5544 FAX #: (317)581-9513

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
2. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
3. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
4. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
5. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
6. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
7. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
8. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
9. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
10. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
TOTALS		\$ <u> </u>	\$ <u> </u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

A. Square Feet:
 44,000
 B. General Construction Type:
 Exterior
 BRICK & BLOCK
 Frame
 Number of Stories
 1

C. Does the Operating Entity?
 ☒ (a) Own the Facility
 ☐ (b) Rent from a Related Organization.
 ☐ (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?
 ☒ (a) Own the Equipment
 ☐ (b) Rent equipment from a Related Organization.
 ☐ (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?
 ☒ YES
 ☐ NO
 If so, please complete the following:

1. Total Amount Incurred:
 4,000
 2. Number of Years Over Which it is Being Amortized:
 5

3. Current Period Amortization:
 667
 4. Dates Incurred:
 5/10/01

Nature of Costs:
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	44,000	not available	\$	1
2					2
3	TOTALS	44,000		\$	3

Facility Name & ID Number Convalescent Care Ctr-Mattoon

0036897

Report Period Beginning:

1/1/2002

Ending:

10/31/2002

XL OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
Bed*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4		2001		\$ 60,029	\$ 2,001	30	\$ 2,001	\$	\$ 3,168
5									
6									
7									
8									
Improvement Type**									
9	1991 Improvements	1991		2,760		10			2,760
10	1992 Improvements	1992		8,389	318	10	318		8,389
11	1993 Improvements	1993		12,963	1,296	10	1,296		12,076
12	1994 Improvements	1994		167,423	16,742	10	16,742		87,236
13	1995 Improvements	1995		191,206	19,121	10	19,121		83,836
14	1996 Improvements	1996		26,012	2,601	10	2,601		19,124
15	1997 Improvements	1997		180,842	16,440	11	16,440		57,646
16	Sewer roofer	1998		1,017	102	10	102		509
17	Heat Unit - rooftop Smoke alarm - detection security	1998		3,210	214	15	214		1,070
18	Smoke alarm - detection security	1998		2,522	252	10	252		1,261
19	Carpeting - alzheimer's unit	1998		2,516	252	10	252		1,237
20	Kitchen floor tile	1998		908	91	10	91		401
21	Security system	1998		3,523	235	15	235		976
22	Water line	1998		5,871	235	25	235		1,096
23	Concrete at front entrance	1998		2,650	177	15	177		781
24	Renovation	1998		1,000	100	10	100		475
25	1997 remodel - curtains	1998		1,461	146	10	146		730
26	1997 remodel - bath decorating	1998		941	94	10	94		470
27	1997 remodel - fixtures	1998		1,140	114	10	114		570
28	Phone system	1998		16,533	3,307	5	3,307		14,604
29	Exterior door mag locks	1999		6,526	653	10	653		2,448
30	Wallcovering main door	1999		2,488	249	10	249		892
31	5 ton A/C roof NE Hall	1999		8,554	855	10	855		2,994
32	Boiler for NW Hall	1999		1,000	67	15	67		267
33									
34									
35									
36									

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	Heil a/c unit - kitchen	1999	\$ 2,927	\$ 293	10	\$ 293	\$	\$ 1,000		37
38	2 rooftop units	1999	8,554	855	10	855		2,922		38
39	Dietary a/c unit	1999	1,301	130	10	130		434		39
40	3 Pole switch in main elec. Panel	1999	953	64	15	64		212		40
41	Replace roof	2000	6,070	607	10	607		1,619		41
42	Ceramic wall tile	2000	1,528	102	15	102		229		42
43	Water heater	2000	2,450	163	15	163		354		43
44	Kick-plates for doors	2000	1,678	168	10	168		420		44
45	Furnace	2000	2,038	136	15	136		272		45
46	Painting - Alzheimer unit	2001	13,352	2,670	5	2,670		4,228		46
47	Door alarm - alzheimer unit	2001	12,441	829	15	829		1,313		47
48	Replace exiting Boiler	2002	2,095	105	20	105		105		48
49	Roofing material	2002	833	83	10	83		83		49
50	Financial Statement Depreciation (Adjustment)			(38,416)			38,416			50
51										51
52										52
53										53
54										54
55										55
56										56
57										57
58										58
59										59
60										60
61										61
62										62
63	(DON'T ENTER BELOW THIS LINE)									63
64	Total (This Page)									64
65										65
66										66
67										67
68										68
69										69
70	TOTAL (lines 4 thru 69)		\$ 767,704	\$ 33,451		\$ 71,867	\$ 38,416	\$ 318,207		70

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)									
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.									
1	2	3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 767,704	\$ 33,451		\$ 71,867	\$ 38,416	\$ 318,207	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 767,704	\$ 33,451		\$ 71,867	\$ 38,416	\$ 318,207	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 767,704	\$ 33,451		\$ 71,867	\$ 38,416	\$ 318,207	1
2									2
3									3
4									4
5									5
6									6
7									7
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9									9
10									10
11									11
12									12
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17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 767,704	\$ 33,451		\$ 71,867	\$ 38,416	\$ 318,207	34

**Improvement type must be detailed in order for the cost report to be considered complete.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 767,704	\$ 33,451		\$ 71,867	\$ 38,416	\$ 318,207	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 767,704	\$ 33,451		\$ 71,867	\$ 38,416	\$ 318,207	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 767,704	\$ 33,451		\$ 71,867	\$ 38,416	\$ 318,207	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
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10									10
11									11
12									12
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 767,704	\$ 33,451		\$ 71,867	\$ 38,416	\$ 318,207	34

**Improvement type must be detailed in order for the cost report to be considered complete.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 767,704	\$ 33,451		\$ 71,867	\$ 38,416	\$ 318,207	1
2									2
3									3
4									4
5									5
6									6
7									7
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10									10
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30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 767,704	\$ 33,451		\$ 71,867	\$ 38,416	\$ 318,207	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 767,704	\$ 33,451		\$ 71,867	\$ 38,416	\$ 318,207	1
2									2
3									3
4									4
5									5
6									6
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 767,704	\$ 33,451		\$ 71,867	\$ 38,416	\$ 318,207	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		\$ 767,704	\$ 33,451		\$ 71,867	\$ 38,416	\$ 318,207	1
2									2
3									3
4									4
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28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 767,704	\$ 33,451		\$ 71,867	\$ 38,416	\$ 318,207	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 767,704	\$ 33,451		\$ 71,867	\$ 38,416	\$ 318,207	1
2									2
3									3
4									4
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31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 767,704	\$ 33,451		\$ 71,867	\$ 38,416	\$ 318,207	34

**Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 223,414	\$ 25,371	\$ 25,371	\$	7	\$ 147,151	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 223,414	\$ 25,371	\$ 25,371	\$		\$ 147,151	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 991,118	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 58,822	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 97,238	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 38,416	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 465,358	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES ☒ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	<u>N/A</u>			\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☒ NO Terms: N/A *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

☐ YES ☒ NO

16. Rental Amount for movable equipment: \$ 2,656 Description: See attached detail for rental expense

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>N/A</u>		\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning

Ending

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2003 \$

13. /2004 \$

14. /2005 \$

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	2. CLASSROOM PORTION:	3. CLINICAL PORTION:
	IN-HOUSE PROGRAM <input type="checkbox"/>	IN-HOUSE PROGRAM <input type="checkbox"/>
	IN OTHER FACILITY <input type="checkbox"/>	IN OTHER FACILITY <input type="checkbox"/>
	COMMUNITY COLLEGE <input type="checkbox"/>	HOURS PER AIDE _____
	HOURS PER AIDE _____	

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a, 3	hrs	\$	1,186	\$ 20,102	\$ 0	1,186	\$ 20,102	1
2	Licensed Speech and Language Development Therapist	10a, 3	hrs		966	17,597	0	966	17,597	2
3	Licensed Recreational Therapist		hrs		0	0	0			3
4	Licensed Physical Therapist	10a, 3	hrs		2,181	27,194	0	2,181	27,194	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$	4,333	\$ 64,893	\$	4,333	\$ 64,893	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 211,766	\$	1
2	Cash-Patient Deposits	30,081		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	71,034		3
4	Supply Inventory (priced at)	13,140		4
5	Short-Term Investments			5
6	Prepaid Insurance	213,198		6
7	Other Prepaid Expenses	1,396		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 540,615	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	683,405		14
15	Leasehold Improvements, at Historical Cost	2,650		15
16	Equipment, at Historical Cost	307,377		16
17	Accumulated Depreciation (book methods)	(426,747)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	4,000		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(1,200)		20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 569,485	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,110,100	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 466,324	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	30,081		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	10,952		30
31	Accrued Taxes Payable (excluding real estate taxes)	(6,977)		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Other accrued expenses	95,137		36
37		154,138		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 749,655	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	311,000		39
40	Mortgage Payable			40
41	Bonds Payable	295,595		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 606,595	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,356,250	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (246,150)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,110,100	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 217,980	1
2	Restatements (describe):		2
3	Restatements of Prior Year to allow rollforward		3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 217,980	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(464,133)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) PRIOR YR ADJ - DEPREC	3	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (464,130)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (246,150)	24 *

* This must agree with page 17, line 47.

VII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 2,121,106	1
2	Discounts and Allowances for all Levels	14,438	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,135,544	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	135,002	6
7	Oxygen	9,875	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 144,877	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	89	13
14	Non-Patient Meals	5,127	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	56,732	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	2,698	19
20	Radiology and X-Ray		20
21	Other Medical Services	73,936	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 138,582	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Transportation	30,165	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 30,165	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,449,168	30

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	625,585	31
32	Health Care	1,251,239	32
33	General Administration	717,748	33
	B. Capital Expense		
34	Ownership	124,069	34
	C. Ancillary Expense		
35	Special Cost Centers	113,492	35
36	Provider Participation Fee	81,168	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,913,301	40
41	Income before Income Taxes (line 30 minus line 40)**	(464,133)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (464,133)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

STATE OF ILLINOIS

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Facility Name & ID Number Convalescent Care Ctr-Mattoon# 0036897Report Period Beginning: 1/1/2002Ending: 10/31/2002

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	5,896	5,896	\$ 153,644	\$ 26.06	1
2	Assistant Director of Nursing					2
3	Registered Nurses	933	933	39,487	42.32	3
4	Licensed Practical Nurses	13,538	13,538	325,810	24.07	4
5	Nurse Aides & Orderlies	37,707	37,707	390,094	10.35	5
6	Nurse Aide Trainees	1,426	1,426	14,777	10.36	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	3,476	3,476	27,474	7.90	10
11	Social Service Workers	6,296	6,296	71,771	11.40	11
12	Dietician	15,629	15,629	134,785	8.62	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	3,112	3,112	32,065	10.30	17
18	Housekeepers	13,341	13,341	87,133	6.53	18
19	Laundry	6,455	6,455	41,037	6.36	19
20	Administrator	1,656	1,656	47,913	28.93	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	4,674	4,674	55,428	11.86	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,750	1,750	14,327	8.19	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	115,889	115,889	\$ 1,435,745 *	\$ 12.39	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	101	\$ 4,234	1, 3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant	144	8,912	10, 3	38
39	Pharmacist Consultant	97	4,272	10, 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	36	2,246	11, 3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48	Admin/Gen	65	2,717	0	48
49	TOTAL (lines 35 - 48)	443	\$ 22,381		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	387	\$ 14,697	10, 3	50
51	Licensed Practical Nurses	2,421	72,490	10, 3	51
52	Nurse Aides	301	5,094	10, 3	52
53	TOTAL (lines 50 - 52)	3,109	\$ 92,281		53

Facility Name & ID Number Convalescent Care Ctr-Mattoon# 0036897Report Period Beginning: 1/1/2002Ending: 10/31/2002

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			Ownership	Amount	D. Employee Benefits and Payroll Taxes			Amount	F. Dues, Fees, Subscriptions and Promotions		Amount			
Name	Function	%			Description				Description					
Suzanne Boston, Barbara Chasteen, Carolyn	Admin.	0	\$	47,913	Workers' Compensation Insurance	\$	54,015		IDPH License Fee	\$				
					Unemployment Compensation Insurance		0		Advertising: Employee Recruitment		8,156			
					FICA Taxes		122,737		Health Care Worker Background Check					
					Employee Health Insurance		10,814		(Indicate # of checks performed <u>169</u>)					
					Employee Meals		0							
					Illinois Municipal Retirement Fund (IMRF)*		0		Dues & Subscriptions		5,162			
					Other Benefits		277		Advertising & Public Relations		12,757			
							0							
							0							
TOTAL (agree to Schedule V, line 17, col. 1)														
(List each licensed administrator separately.)				\$	47,913									
B. Administrative - Other														
Description				Amount	Home Office Allocation				Home Office Allocation					
				\$				Less: Public Relations Expense (
								Non-allowable advertising			(12,757)			
								Yellow page advertising						
					TOTAL (agree to Schedule V, line 22, col.8)			\$	187,843	TOTAL (agree to Sch. V, line 20, col. 8)		\$	13,318	
TOTAL (agree to Schedule V, line 17, col. 3)				\$	E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**					
(Attach a copy of any management service agreement)					Description			Line #	Amount	Description			Amount	
C. Professional Services					N/A					Out-of-State Travel			\$	
Vendor/Payee	Type		Amount											
Legal Fees	Various		11,711											
Purchased Service	Various		2,717											
Data Processing	Various		20,478											
Accounting	Various		6,661											
Professional Services	Various		1,750											
Management Fees	Various		134,701											
TOTAL (agree to Schedule V, line 19, column 3)					TOTAL			\$		Seminar Expense			0	
(If total legal fees exceed \$2500 attach copy of invoices.)				\$	178,018					Business Meals				
										Home Office Allocation				
										Entertainment Expense				
										(agree to Sch. V, line 24, col. 8)				
										TOTAL			\$	11,577

* Attach copy of IMRF notifications

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

[illegible]

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN, LPN, NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? Yes If YES, what is the capacity? 134
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 7
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 9,678 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 81,168
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? Yes Indicate the amount. \$ 3,921
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? 0
- d. Have vehicle usage logs been maintained? Yes
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Firm Name: n/a The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N If no, please explain. Not required
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.